Victorian Oral Health Alliance

VOHA ELECTION PLATFORM 2026

Why action on oral health now?

Good oral health is fundamental — but access to prevention and care is far from equally available to all Victorians, and levels of public adult care have not shifted for a long time. There needs to be progress in the next term of Parliament.

Stark inequities persist in oral health and have worsened in the last decade.

Despite improvements made over the decades (e.g. 95% Victorians have access to fluoridated water and the major investment made in rebooting a prevention-focused school dental service), hundreds of thousands of Victorians at the highest risk of oral disease continue to be left behind. Demand outruns public supply leaving long waiting lists, likely to increase as cost-of-living pressures increase, and preventive activities are not at scale. These drive persistently high rates of potentially preventable dental hospitalisations, especially for pre-school children.

Public dental programs in Victoria face growing constraints with government funding declining by approximately 28% per consumer in real (CPI-adjusted) terms since pre-COVID times (FY19-20), reducing the financial viability of community-based delivery models.

Those disproportionately affected by inadequate prevention and appropriate early-intervention include rural Victorians, the growing number of older people, pre-school aged children, culturally and linguistically diverse communities, First Nations people, people affected by mental health issues, including alcohol and other drugs, victims of domestic violence, and others on low-incomes.

Key problems and three headline solutions

PROBLEM 1

- Many more adults needing public care than funding/ infrastructure/ workforce can provide, with wait times remaining unreasonably long (budgeted funding on average only stretches for care once every seven years for every eligible adult).
- This is a decade old problem that desperately needs fixing, but likely to get worse with current cost-of-living pressures increasing demand.
- Demand increasing, e.g. via an ageing population, keeping their teeth longer but with impact of increased rate of multiple medications on the mouth, alongside lack of personal and clinical oral health care in community and residential aged care settings.

SOLUTION 1

Invest more money into adult public dental care - *Fair access, lower avoidable hospital costs*

- Gradually scale up capacity of the system by adding $40 million extra each year ongoing.
- Allocate ~75% service expansion ($30m) for adult care, potentially enabling an extra 75,000 people to be treated over four years. Include updating funding model and coverage for interpreters and rural transport assistance.
- Allocate ~25% ($10M) to ensure sustainable workforce. (e.g. salary uplifts to competitive rates, rural incentives as viable attraction/retention strategies – see below).
- Advocate more strongly to the Federal Government for a Senior Dental Benefits Scheme.

PROBLEM 2

- Waste of existing infrastructure. Official estimates report 50% of existing chairs (esp. rural) are unstaffed, sitting idle, and depreciating.
- Difficulties attracting and retaining workforce in publicly funded services (especially rural).

SOLUTION 2

Unlock rural capacity - *Open idle or under-utilised chairs we already have*

As part of investment above, address under-used chairs and workforce shortages via:

- A Rural Infrastructure Utilisation Package to turn existing but under-used dental chairs into care.
- A Victorian incentive graduate year program (aligned with salary competitiveness) to stabilise teams and unlock infrastructure.

SOLUTION 2

- Incentives for experienced metro clinicians to work part-time in rural areas (inc. travel/commute costs), plus greater pd assistance to retain existing staff.

PROBLEM 3

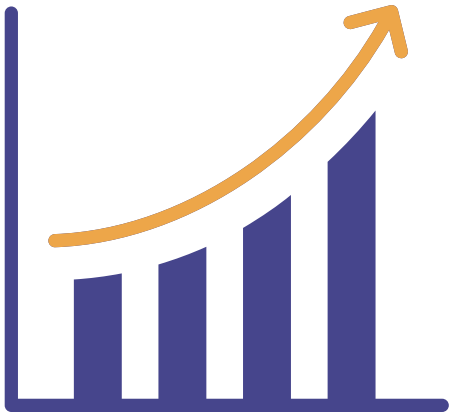
- No measurable progress on the Government's own VAPPOD 2020-30 oral health goals (e.g. access to fluoridated water in 10% of rural/regional Victoria, and little progress in recent years)
- Lack of community awareness in unfluoridated areas
- High rates of children entering school with tooth decay (34% in 2020)
- Gaps in Smile Squad delivery
- Unacceptably high and increasing rates of preventable hospital admissions for children, esp. aged under 9 years). (Care often requires a general anaesthetic (an undesirable option for younger children), and the high rate is an expensive problem for the state, the healthcare system, and families taking time off work and school to undergo this level of care.)
- Every filling a child has (that could have been prevented) imposes a lifetime requirement for regular replacements

SOLUTION 3

Scale up prevention with multi-disciplinary teams and place-based care - *Dental prevention is everyone's business*

- Fund four new rural water fluoridation upgrades annually - (the most equitable as well as most cost-effective preventive measure) ($8m p.a.) until government's 95% target met.
- Scale up existing pre-school programs (e.g. Smiles for Miles).
- Resource pharmacists, nurse practitioners, maternal and child health nurses, and aged-care clinicians to deliver opportunistic screening, health education, and appropriate referrals.

Expected outcomes for whom?



$40M =

increase annually

Invest more money into adult public dental care -

will benefit:

all eligible adults, particularly for Victorians at increased risk of oral health problems (rural Victorians, older people, our culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, people affected by mental health issues, including alcohol and other drugs, victims of domestic violence, people on low incomes).

Outcomes

- Fairer access to care.
- Less active oral disease, helping to stabilise the long-term demand burden on services and lower need for emergency care.
- More people treated faster in clinics, reducing the level of emergency treatments and increasing care for people on the waiting lists.
- Greater capacity of services to recruit and retain workforce.

Unlock rural capacity -

will benefit:

Rural Victorians generally, especially in non-fluoridated areas.

Outcomes

- Fairer access to care.
- More productive utilisation of existing infrastructure.
- More workforce for local public clinics and Smile Squad.

Scale up prevention with multi-disciplinary teams and place-based care -
will benefit:
Children, especially pre-school, rural Victorians generally but especially in non-fluoridated areas, older adults.

Outcomes

- Increased number of rural children having access to fluoridated water.
- Better informed children and families in yet-to-be fluoridated areas.
- Less active oral disease, including whole populations in newly fluoridated areas.
- Reduced pressure on hospitals from preventable ED presentations and hospitalisations.
- Resource pharmacists, nurse practitioners, maternal and child health nurses, and aged-care
- clinicians to deliver opportunistic screening, health education, and appropriate referrals.
- Increasing awareness of eligibility for Commonwealth-funded private care via the CDBS.

These should all contribute to progress towards a sector with appropriately funded services, skilled workforce, stronger prevention, measurable impact, utilising the private sector where appropriate, and every public dollar working harder to meet the needs of vulnerable, at-risk populations Victorians, and maximising the return on public investment.

Our Member Organisations

ADA VICTORIA

ADPA

cohealth care for all

COTA VICTORIA

Each

East Grampians Health Service

ipc Health

Latrobe Community Health Service

The University of Melbourne Melbourne Dental School

NIOH Australian Network for Integration of Oral Health

OHAA Oral Health Association of Australia

Public Health Association Australia

vaada Victorian Alcohol & Drug Association

Victorian Healthcare Association Vision • Value • Voice

La Trobe University | Violet Vines Marshman Centre for Rural Health Research

your COMMUNITY HEALTH

Appendix - useful content for Public Oral Health care and prevention

Funding landscape: where dental fits

- Hospitals are jointly funded by the Commonwealth and States under the National Health Reform Agreement (NHRA).
- Primary health care (MedicarePBS) is predominantly Commonwealth-funded.
- Public oral health is predominantly state-funded, with targeted Commonwealth top-ups (e.g. Child Dental Benefits Schedule and adult-dental Federation Funding Agreements measured in DWAUs).
- Services receive their funding from Oral Health Victoria based on the number of units of care they provide in a year. OHV also provides some other extra funding for specific reasons.

Workforce context

- **The gap:** We are training more oral health professionals each year, but public services struggle to recruit and retain, especially outside metro Melbourne, driving under-utilisation of funded infrastructure.
- **What works elsewhere:** The Commonwealth has legislated HELP debt waivers/reductions for rural doctors and nurse practitioners (MMM3–7), recognising location-based service as a public good. A Victorian dental workforce incentive modelled on this (State top-up or parallel HECS offset) would be practical and consistent with national policy architecture. [education.gov.au]
- **Why the salary lever matters:** Peak bodies highlight wage competitiveness as a binding constraint in the Victorian public system (e.g. dentists are paid 30% less than their NSW counterparts, and even less than in private sector, as are other oral health practitioners). Targeted uplift improves recruitment/retention and reduces expensive locum reliance. [adavb.org]

Who provides the services?

- Predominantly community health services (both independent and those part of hospital services), some rural hospitals.
- Specialist services via a number of regional clinics and centrally at Oral Health Victoria.